

# MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred, or expires)

TO: Alabama Medicaid Agency  
P.O. Box 5624-36103  
501 Dexter Avenue  
Montgomery, Alabama 36104

Date \_\_\_\_\_

FROM: \_\_\_\_\_ Provider Number \_\_\_\_\_  
(Name of Facility)  
\_\_\_\_\_  
(Address of Facility) Telephone Number \_\_\_\_\_

## CURRENT PATIENT STATUS

Patient's First Name M.I. Patient's Last Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Birthdate \_\_\_\_\_

Patient's Social Security No.           Female ☐

Patient's Medicaid No.             Male ☐

Date Admitted \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Medicare Admission) (Medicaid Admission)

Number of Medicare Days this Admission: \_\_\_\_\_

☐ New Admission ☐ Hospital ☐ Mental Institution  
☐ Re-Admission From: ☐ Home  
☐ Transferred Admission ☐ Other Nursing Home \_\_\_\_\_

### For Medicaid Use Only:

Over 60-days late \_\_\_\_\_

Medicare Denial: \_\_\_\_\_

Reference Information: \_\_\_\_\_  
Name of Sponsor

Address of Sponsor

☐ Mental Illness ☐ Developmentally Disabled  
☐ Convalescent Care ☐ Post Extended Care Days ☐ Swing Bed Approved By \_\_\_\_\_  
☐ Dual Diagnosis ☐ Mental Retardation Date Approved: \_\_\_\_\_

## PATIENT DISCHARGE STATUS

Discharged to: \_\_\_\_\_ Date \_\_\_\_\_

Death (Date) \_\_\_\_\_

Signed \_\_\_\_\_

Title \_\_\_\_\_

### Distribution:

White: Alabama Medicaid Agency

Blue: Office of determination for Medicaid eligibility - check one:

☐

SSI

☐

D.O.

Pink: Nursing Home File Copy

District Office

Physician's current orders:  
(a copy of orders may be attached)

(Please list nursing homes and dates they were contacted for placement. This form must be documented every 15 days.)

Date \_\_\_\_\_

**Contacted**

RN Signature

(Physician must sign and date)

Date \_\_\_\_\_